COMMISSIONER'S WAIVER DRUG & ALCOHOL RELEASE
Authorization to Disclose Protected Health and Substance Abuse Treatment Information to the Vermont Department of Corrections (DOC)

Incomplete information: An incomplete form will result in a defective authorization. Please make sure you fill in the entire form.

I, ____ Social Security #: ______-_____-______
(*name of offender*) Date of Birth: _______________________

Authorize:

____

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(*name & address of person/organization to make the disclosure*)

to disclose the following information to the **Vermont Department of Corrections, 103 South Main Street, Waterbury, VT 05671 – (802) 951-5003.**

Type of Health Information

(Circle RELEASE or DON'T RELEASE for each type of information so only the appropriate information is released):

Entire Medical / Treatment Record	Release	Don't Release
Diagnosis / Presenting Problem	Release	Don't Release
Assessment Summaries / Evaluations	Release	Don't Release
Treatment Recommendations	Release	Don't Release
Treatment Plan / Support Agreement	Release	Don't Release
Progress Report on Treatment / Support	Release	Don't Release
Discharge Summary / Plan	Release	Don't Release
Medication Prescribed	Release	Don't Release
Test Results (specify): ____________________	Release	Don't Release
Mental Health Records/Psychotherapy Notes	Release	Don't Release
Drug and Alcohol Information	Release	Don't Release

Other (be specific): ____

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The Health and Substance Abuse Treatment Information to be released was created in the **time period:**

from ______________________________ to _________________________________;
Beginning date Ending date

or was created for: ____
E.g., treatment of particular condition or other specific health issue

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The purpose of this disclosure is to inform the DOC of my participation and progress in substance abuse treatment to be used in consideration of potential employment and my Commissioner's Waiver Application.

Means of disclosure (*check all that apply*):
☐ Written ☐ Oral ☐ Electronic ☐ Other: ________________________________

I have read and understand the following:

- The reason(s) I am being asked to release information.
- I do not have to consent to the release of this information.
- Signing this authorization is voluntary. If I choose not to sign, my treatment will not be affected.
- If I am authorizing DOC to share information about **alcohol or drug treatment**, the recipient may not share my information with others unless permitted to do so under state or federal law.
- I may revoke this authorization at any time except to the extent the person/organization authorized to disclose information has already acted in reliance on it. To revoke this authorization, I must sign the revocation section of this form and submit it to the person/organization authorized to disclose information.

Date or event upon which this authorization will expire: ____________________________. I understand that if I do not specify a date or event, then this authorization will expire on:

____
(*specific date, event, or condition*)

Individual's Signature: ________________________________ Date: ________________

REVOCATION

I hereby revoke this authorization on ___________________________ (date) at _______________ (time). Do not release any further information under this authorization.

Signature: ____

Send the completed authorization to the person/organization authorized to disclose information